The Emergence of Psychiatric Disabilities in Postsecondary Education

Michael N. Sharpe, Brett D. Bruininks, Barbara A. Blacklock, Betty Benson, & Donna M. Johnson

The Issue

One of the more significant developments which has occurred in the field of postsecondary disability supports in the last decade has been the proliferation of individuals declaring a psychiatric disability. In comparison to most other disability areas, this phenomenon has occurred with only the briefest of latency periods, having emerged at a pace that has been characterized by one observer as a "rising tide" (Eudaly, 2003). However, aside from numerous anecdotal reports (Eudaly, 2003; Sharpe & Bruininks, 2003) little actuarial information exists regarding the presence of individuals with psychiatric disabilities in the postsecondary settings. For example, "psychiatric disabilities" did not appear as a separate category in *Students with Disabilities in Postsecondary Education: A Profile of Preparation, Participation and Outcomes,* a report prepared by the National Center for Educational Statistics (NCES, 1999). A similar observation was made in a review of *College Freshman with Disabilities: A Biennial Statistic Profile* compiled by the Heath Resource Center (2001). Despite its apparent propensity for eluding capture on national databases, there appears to be increasing agreement among experts and "frontline" service providers alike, that greater numbers of individual with psychiatric disabilities are seeking support services and accommodations in the postsecondary setting. While most evidence of this growth can only be offered though a collection of "armchair" estimates and anecdotal reports, the results are nevertheless revealing. For example, Measel (1999) found that within one year, five institutions in the Big Ten Conference encountered an increase from 30% to 100% in the number of students served with psychiatric disabilities. At one of these institutions alone, the University of Minnesota, it was found that the number of students reporting a psychiatric disability as their primary disability (285) eclipsed the combined number of students with learning disabilities and attention deficit disorders (269). Even though little exists in the way of systematically collected data to provide for a reliable estimate of the emergence of psychiatric disabilities in postsecondary education, information obtained from currently available sources, however informal or anecdotal, provide mounting evidence that this is an issue that is very likely to come into sharper focus as more data/information studies become available.

Despite its relatively recent appearance in the postsecondary setting, the growth in the numbers individuals declaring a psychiatric disability is not altogether inconsistent with national statistics. For example, in any given year, it has been estimated that about one in five Americans experience a diagnosable psychiatric disability which includes major depressive disorders, schizophrenia, eating disorders, and anxiety disorders (National Institute of Mental Health, 2000). By their very nature, a number of psychiatric disabilities remain dormant, manifested only at critical stages of human psychosocial development. Unger (1992) observed that the onset of major mental illness occurs between the ages of 18-25—a time when many young adults are seeking postsecondary education, preparing for future careers, and developing social relationships.

Perhaps the most influential factor resulting in increasing numbers of individuals declaring a psychiatric disorder in the postsecondary setting is the manner in which such disabilities are now being identified and treated. Today diagnostic criteria have expanded to the point that the term "psychiatric disability" represents a much broader range of disorders and

syndromes than any time before. Whereas once much of the attention was largely focused on the diagnosis and treatment for the "major" psychopathologies (e.g., schizophrenia), the field has broadened considerably to encompass disorders generally requiring less intensive treatment interventions. For example, within the last decade or so, there has been a rather dramatic increase in the identification and treatment of a number of anxiety disorders, particularly those related to social anxiety, post-traumatic stress, and various types of phobic disorders. Although no less debilitating than other types of psychiatric disabilities, the advent of major advances in pharmacology have reduced the need for more intensive, long-term treatment interventions. As diagnostic criteria continue to improve in identifying other types of mental health disorders, it is likely the population of students with psychiatric disabilities in postsecondary education settings will continue to grow.

Current Research and Practice

Much of the early efforts to address the needs of individuals with psychiatric disabilities within the postsecondary setting occurred as a result of the emergence of "supported education" programs. Based on the definition of "supported employment" of the Rehabilitation Act Amendments of 1986, supported education programs began in the 1980's (Unger, 1998) as a way of providing supports to individuals with psychiatric disabilities in the postsecondary setting. According to Unger (1998), supported education programs involve three "prototypes": (1) a self-contained setting, where students are reintegrated into the postsecondary setting, (2) "on-site" support, where ongoing support is provided by the institution's disabilities support staff or a mental health professional, and (3) "mobile" support, where support is largely provided by community mental health service providers. It is estimated that about 30 supported education programs are currently in existence to serve individuals with psychiatric disabilities in postsecondary programs.

While supported education continues to serve as a model for serving the needs of individuals with psychiatric disabilities, the more typical case is that students with psychiatric disabilities are served by what may generically be referred to as Disability Support Services (DSS) staff at the postsecondary level. Many of these staff members have traditionally received training in a disability area related to learning and instruction (e.g., Learning Disabilities) and consider themselves not adequately trained to address the needs of individuals with psychiatric disabilities. Indeed, some DSS staff report that they are often challenged in meeting the needs of students with psychiatric disabilities. They indicate efforts to provide accommodations are not as "clear cut" as other disability areas (Sharpe & Bruininks, 2003) or that working with students with psychiatric disabilities will sometimes require addressing a host of multiple, complex problems such as social isolation, withdrawal, along with academic failure (Blacklock, Benson & Johnson, 2003). Clearly, serving students with psychiatric disabilities in the postsecondary setting represents new challenges to many DSS providers.

While there is only limited research on this issue to guide practice, information has recently become available that helps to identify some of the barriers faced by students with psychiatric disabilities and service providers alike (Blacklock, Benson & Johnson, 2003). Based on the results of 39 focus groups conducted with postsecondary Disability Support Services staff, faculty and administrators, and students with psychiatric disabilities, (Blacklock, et al., 2003) identified five primary barriers that impact the educational experiences of students and service delivery issues for providers, which include:

Stereotypes and Stigma—Most commonly identified by all types of focus groups, students with psychiatric disabilities are often faced with incorrect, stereotypical views about their disability and endure the stigma that frequently accompanies disclosure of such a disability.
Complex Nature of Psychiatric Disabilities—Student groups in particular feel challenged to simultaneously manage their disability and maintain an acceptable level of academic performance.
Access to Resources—All focus groups contended that students with psychiatric disabilities face barriers by having to seek and acquire resources, particularly insurance coverage, to maintain supports that are needed (e.g., psychological, counseling) to address their disability.
Access to Information and Services—Many student focus groups expressed frustration with the lack of information about psychiatric disabilities and limited access to services that would allow them to effectively manage their disability.
Organizational and Institutional—A lack of service coordination and communication between service providers was identified by focus groups who provide support services to students with disabilities at the postsecondary level.

The identification of these barriers indicated above appears to be consistent with what has been generally observed by others (Collins, 2001; Eudaly, 2002; Loewen, 1993; Pugh, 2002; Unger, 1992). To address these barriers, Blacklock, Benson & Johnson (2003) advocate that four specific strategies be employed: (1) implementing Universal Instructional Design strategies to improve the learning experiences for all students, including those with psychiatric disabilities, (2) creating sub-communities to foster social connections for students with psychiatric disabilities, (3) improving clarity, coordination, and communication with all key stakeholders, including inter-organizational and community-based service providers, and (4) promoting access to resources for all key stakeholders through information dissemination and training efforts.

A common theme throughout much of the literature relating to the support of students with psychiatric disabilities involves how such services should be configured at the postsecondary level. These ideas not only involve the “mission” or “values” of the program (Unger, 1998), they also include clearly articulating the parameters upon which students will be served. In the case of the former, efforts to outline overall program mission and values will establish the “scope” of services relative to the institutional and community resources available. This activity can also be helpful in accomplishing the latter task, which is to clearly define how support services will be accessed and maintained by students with psychiatric disabilities. Through a series of interviews conducted with DSS staff in “Big Ten” universities and colleges, Sharpe & Bruininks (2003) identified several basic requirements common to these institutions:

Documentation—Students with psychiatric disabilities must provide current documentation by a qualified medical or mental health professional to qualify for DSS services.
Diagnostic Criteria—Generally, a diagnosis must reflect criteria established by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the International Classification of Diseases Manual, Tenth Edition (ICD-10). Moreover, the diagnosis must meet disability criteria established by the Americans with Disabilities Act (ADA).
Accommodations—Although clinical input regarding functional limitations and instructional accommodations are considered, DSS staff generally make the final determination regarding what specific accommodations will be provided.

Accountability—In nearly all cases, the declaration of a psychiatric disability does not exempt one from the Code of Conduct and similar policies established by the institution.
Some variability was noted, however, in the processes used to notify postsecondary instructional staff about the need for accommodations. In some cases, the student is obligated to discuss the need for accommodations directly with the instructor. In other cases, a letter or memo was sent to the instructor by DSS staff regarding accommodation needs for a student. Variations on these two general themes were also noted (Sharpe & Bruininks, 2003).

While this overview provides some basic elements of current research and practice with regard to serving students with psychiatric disabilities in postsecondary settings, much more work needs to be done. At this point, only a small glimpse has been captured about this growing population of students. For instance, much has yet to be learned about the overall nature of students with psychiatric disabilities entering postsecondary education settings. Currently little accurate information exists regarding the overall prevalence and variability of students with psychiatric disabilities. For example, little is known about how many of these students exhibit "severe and persistent" disorders in relation to those considered "mild." This evidence alone would do much to illuminate the extent to which the general population of students with psychiatric disabilities represent those who may be in need of continuous and intensive therapeutic interventions as opposed to those who may be able to self-regulate their daily living routine through pharmacological treatment, along with occasional follow-up by institutional or community-based counseling services.

Strategies for Practice

Despite the paucity of empirical evidence regarding strategies that will lead to increasing positive academic, social, and employment outcomes specific to students with psychiatric disabilities, a wide range of instructional accommodation have been collected and disseminated through various studies, professional networks, and training activities. These accommodations are shown in Table 1 and reflect those most commonly used—that is, which can be implemented cost-effectively and with relative ease. Providing extra time for tests or assignments or a quiet environment for studying are two frequently used accommodations. Also, encouraging students to communicate with the instructor is also a strategy that can be employed.

It is noteworthy to point out the accommodations in the table are "universal" in the sense that they are generally equally applicable to most types of disabilities. This represents the "good news" about providing accommodations to students with psychiatric disabilities in the postsecondary setting—accommodation types differ little from those typically provided to all students with disabilities. In a recent study conducted by Sharpe, Johnson & Murray (in press, 2003), few differences were observed in the types of accommodations provided to students with psychiatric disabilities in comparison to other types of disabilities. In short, the findings of this study indicate that, irrespective of disability type, the accommodations provided to students with psychiatric disabilities are generally the same as those provided to students with all types of disabilities. What continues to remain unknown, of course, is how effective these types of accommodations are for students with psychiatric disabilities.

But even before considering what types of instructional strategies should be employed for students with psychiatric disabilities, it may be more important for some to reflect upon broader, programmatic issues—specifically, the mission of the DSS provider and the policies that may—

or may not—be in place to address the needs of students with psychiatric disabilities in the postsecondary setting. Perhaps most importantly, postsecondary support staff need to realize that, unless so trained and licensed, their role is not that of a mental health professional, nor should they feel compelled to cast themselves in a role that extends beyond the scope their primary responsibility—to facilitate instructional supports for students with disabilities. As succinctly stated by Unger (1998) in a discussion of supported education programs "The college or university is not a treatment setting nor is a supported education program a treatment program…Treatment is the role of the mental health system." Given that rather astute observation, DSS staff should be able to articulate a clearly defined role for themselves and the range of services they can provide to students with psychiatric disabilities. As such, policies need to be designed and implemented to reflect these roles and responsibilities. Several of these polices were presented in the previous section (i.e., Documentation, Diagnostic Criteria, Accommodations, Accountability). One need not "reinvent the wheel" since a number of policies and practices are readily accessible by reviewing websites of various 2- and 4-year postsecondary institutions.

Only when a clear direction has been defined for the DSS program (e.g., a "mission"), will it be possible to identify opportunities for improving or enhancing services to students with psychiatric disabilities. For example, developing collaborative relationships with community-based mental health professionals might be an option to begin building a support network for students with psychiatric disabilities. Closer to "home," DSS staff may opt to communicate with institutional counseling services to serve as adjunct support system for students. Irrespective of the strategy employed, the role of the DSS staff member should only remain as a "facilitator" of services that fall outside the immediate realm of instructional supports. Naturally, this will vary by institution, given the resources and expertise available. Given that many DSS staff are already consumed with excessive caseloads, it will be even more imperative in the future to develop collaborative relationships with all types of partners to develop, implement, and maintain innovative strategies for addressing the needs of students with psychiatric disabilities.

For DSS staff who wish to pursue a more comprehensive approach to providing services to students with psychiatric disabilities in postsecondary settings, a model of supported education provides a template of services which to can be replicated either in part, or in full. As indicated previously, Unger (1998) offers three different prototypes that include a "self-contained" classroom, "on-site support" and "mobile support." In all cases, services are specifically focused on the academic and social needs of students with psychiatric disabilities. Irrespective of the intensity with which any of the prototypes are considered for implementation, Unger's (1998) description of philosophy, mission, values, and program policies is well worth reviewing for any type of program focused on students with psychiatric disabilities.

Muckenhoupt (2000) has suggested that the impact of untreated psychiatric disabilities is "staggering." Only relatively recently has this population emerged within the postsecondary setting, presenting a challenge to service systems and providers alike. While research regarding "best practice" in this area is clearly wanting, efforts continue on behalf of many disability support service providers to develop and implement models of service to meet this challenge. To support these efforts, a "rising tide" of research, information dissemination, and training will also be necessary to match the unparalleled growth that in all likelihood, will continue.

Table 1: Accommodations for Students with Psychiatric Disabilities

- Extra Time for Assignments and Tests
- Quiet Environment for Studying and Tests
- Communicating Needs with Instructor
- Tutorial Assistant
- Priority Registration
- Recording of Lectures
- Notetaker of Lectures
- Preferential Classroom Seating
- Reading Test to Student
- Taped Reading Materials
- Specialized Software
- Class Relocation

References

Blacklock, B., Benson, B., & Johnson, D. (2003). *Needs assessment project: Exploring barriers and opportunities for college students with psychiatric disabilities*. Unpublished manuscript, University of Minnesota.

Collins, K. D. (2001). Coordination of rehabilitation services in higher education for students with psychiatric disabilities. *Journal of Applied Rehabilitation Counseling, 31*(4), 36-39.

Eudaly, J. (2002). A rising tide: Students with psychiatric disabilities seek services in record numbers. *Information from Heath,* 1-4.

Heath Resource Center. (2001). *College freshman with disabilities: A biennial statistic profile*. Heath Resource Center American Council on Education, Washington DC.

Loewen, G. (1993). Improving access to postsecondary education. *Psychosocial Rehabilitation Journal,* 17(1), 151-155.

Measel, D. (1998). *Big ten survey data—1997-1998*. Paper presented at the annual conference of the Association on Higher Education and Disability (AHEAD), Las Vegas, NV.

National Institute of Mental Health. (2002). *Mental disorders in America.* NIH Publication No. 99-4584. Bethesda, MD: Author.

Pugh, A. S. (1999). *Perceptions of college students diagnosed with panic disorder with agoraphobia: Academic, psychosocial, and environmental views of their college experience*. (Doctoral dissertation, Virginia Tech University, ETD-062399-172730).

Sharpe, M. N., & Bruininks, B. D. (2003). *Services for students with psychiatric disabilities in the Big Ten schools*. Unpublished manuscript, University of Minnesota.

Sharpe, M. N., Johnson, D. R., & Murray, A. (2003). *An analysis of instructional accommodations and assistive technologies used by postsecondary graduates with disabilities*. Manuscript submitted for publication.

National Center on Educational Statistics. (1999). *Students with disabilities in postsecondary education: A profile of preparation, participation and outcomes*. A report prepared by National Center for Educational Statistics.

Unger, K. V. (1998). *Handbook on supported education: Service for students with psychiatric disabilities*. Paul H. Brookes Publishing Co.